7. Statistical Research Inc. *AAF/ESPN Children and Sports Media Study: April-May 2001.* Los Angeles, CA: Amateur Athletic Foundation and ESPN; 2001.
8. Ringel JS, Collins RL, Ellickson PL. Time trends and demographic differences in youth exposure to alcohol advertising on television. *J Adolesc Health*. 2006; 39(4):473-480.
9. Winter MV, Donovan RJ, Fielder LJ. Exposure of children and adolescents to alcohol advertising on television in Australia. *J Stud Alcohol Drugs*. 2008;69 (5):676-683.
10. *Submission to the National Alcohol Strategy 2005-2009.* Canberra, Australia: Alcohol and Other Drugs Council of Australia; 2005.
11. *Alcohol Toll Reduction Bill 2007.* Canberra, Australia: Report of the Senate Standing Committee on Community Affairs; 2008:75.
12. *Partner or Foe? The Alcohol Industry, Youth Alcohol Problems, and Alcohol Policy Strategies: Policy Briefing Paper.* Chicago, IL: American Medical Association Office of Alcohol and Other Drug Abuse; 2002.
13. *Reducing Underage Drinking: A Collective Responsibility: Report Brief September 2003*. Washington, DC: National Academy of Sciences; National Research Council and Institute of Medicine of the National Academies; 2003.
14. Fortin RB, Rempel B. *The Effectiveness of Regulating Alcohol Advertising: Policies and Public Health.* Toronto, ON: The Association To Reduce Alcohol Promotion in Ontario, Ontario Public Health Association; 2005.
15. Strasburger VC; Committee on Communications, American Academy of Pediatrics. Children, adolescents, and advertising. *Pediatrics*. 2006;118(6): 2563-2569.

The Ethical Foundation of American Medicine
In Search of Social Justice

Darrell G. Kirch, MD
David J. Vernon, BA

FOLLOWING A HISTORIC ELECTORAL TRANSITION accompanied by an economic downturn unprecedented in the lives of most US residents, attention has once again turned to improving the cost and effectiveness of health care in the United States. While many have described the dysfunctional aspects of the US health care system,[1] the focus has prioritized issues of payment systems[2] and delivery models[3] over a fundamental underlying ethical conflict. Within an ethical context, it is important to discuss how the commercialization of medicine has fostered a distortion of emphasis among the basic tenets of medical ethics, and how this unbalanced emphasis has created serious barriers to improving the health care system.

The teaching of medical ethics has long focused on a 4-pillar foundation of the profession: beneficence (provide good care), nonmaleficence (do no harm), respect for autonomy, and justice.[4] It would appear that in the United States, however, attention to these 4 principles has become unbalanced. Currently, far less emphasis is given to considerations of justice (especially for society as a whole) relative to the other ethical principles.

The Ethical Context for Physicians

From the time of Hippocrates to contemporary practice, the linked principles of beneficence and nonmaleficence have been foremost in the minds of physicians. The goal of beneficence is a compelling factor attracting many to enter the medical profession. Concurrently, with recent efforts to promote patient safety, a renewed emphasis upon nonmaleficence has occured. Additionally, in an interdependent society and complex health care system, respect for autonomy is also receiving more attention.

Respect for autonomy often has been understood to refer only to respect for patient autonomy, but it also subsumes respect for physician autonomy.[5] The patient-physician relationship has shared obligations, and autonomy cannot be considered a unilateral moral right for either the patient or the physician.[5] The physician "is society's agent and as such has delegated authority in matters of health care delivery."[6] Physicians have certain privileges that others do not have because it is assumed that unless physicians hold these rights and responsibilities, the health of society will be compromised. This social contract is at the heart of the medical profession. Physicians must use their best informed judgment when caring for individuals who need assistance and in return, physicians must be given appropriate freedom to do so.[5,7]

In the current system, however, and in the face of the powerful commercial forces at work in health care, the expression of physician autonomy at times appears to have become more aligned with independence of practice, especially fiscal independence and the right to enhance physician revenue (eg, through physician-owned hospitals and imaging centers). In a market-driven environment, fiscal independence seems to have become as important as autonomous decision making in practice, and concomitantly, attention to social justice may be decreased.[8]

The Role of Social Justice

Considerations of justice, especially when viewed in the context of society as a whole, seem underemphasized relative to the other fundamental ethical principles of medicine. In this regard, a major challenge faced by medicine has been the lack of an absolute theory of justice. Throughout time,

Author Affiliations: Association of American Medical Colleges, Washington, DC.
Corresponding Author: Darrell G. Kirch, MD, Association of American Medical Colleges, 2450 N St NW, Washington, DC 20037 (dgkirch@aamc.org).

ethicists have struggled to answer the question, "What is 'just?'"

Rawls' theory of justice, often referred to as social justice, has gained prominence since the 1970s as a dominant theory of justice. This theory has 2 major principles. The first, that "people should have maximal liberty compatible with the same degree of liberty for everyone," defines limits of individual liberty by focusing on the liberty of others.[9] The second, that "deliberate inequalities [a]re unjust unless they work to the advantage of the least well off," focuses on social consequence and responsibility for actions.[9] Considering the body of research and news reports that describe inequalities in US health care access and quality,[10] and the fact that these inequalities do not work to the advantage of the least fortunate, it is clear that the US health system does not meet these criteria for being just. It seems that the structure of incentives in the current health system stimulates behavior that marginalizes considerations of social justice, leaving it seldom emphasized, relative to the other 3 core principles of medical ethics.

How can this inequity persist if physicians believe that the pursuit of social justice requires an active effort on their part, working with others to remedy the situation? Although physicians understand and are aware of their ethical obligations, social responsibilities, and social contract, the persistent imbalance seems to indicate that some physicians believe it is not their personal responsibility to work to rebalance the principles of medical ethics. Perhaps these physicians believe they are doing the best they can given the current sociopolitical circumstances. Before discussing who has the responsibility for correcting this imbalance and how it might be accomplished, it is important to understand some of the potential underlying factors.

Analyzing an Apparent Ethical Imbalance

While multiple forces may contribute to the perceived imbalance, 3 interrelated factors seem especially prominent. The first is fundamental human behavior. Physicians, like most individuals, seek and compete for opportunities within their current circumstance to create the best life possible for themselves and their families. Furthermore, the real or perceived link between having more money and, therefore, more opportunities promotes a focus on maximizing earnings. Complex factors in play include the influential forces behind fee-for-service payments, the divergence between reimbursements for procedures and cognitive services, and the larger income disparities in US society. The net result is a medical culture in which concerns for physician independence and revenue at times seem to outweigh concerns for societal needs.[8]

For example, physicians attempt to maximize income while caring for the needs of their individual patients, but this means that some physicians choose to accept fewer, if any, Medicare and Medicaid recipients, as well as self-pay patients.[11] Some physicians argue that to keep their practice financially viable, they have to see fewer patients for whom they are inadequately reimbursed. Yet for each of the physicians who decide they can no longer care for these patients, the responsibility of care falls to another clinician.[11] This increases the burden on those other clinicians and exacerbates the income disparities among them. In circular fashion, this increases the focus on revenue and reimbursement, rather than on social justice.

A second factor that may contribute to the imbalance of medical ethics in practice involves the cost of education and level of student debt. In recent years, medical school tuition and new physician indebtedness have increased dramatically.[12] Further, a recent analysis of diversity of US medical students by parental income found that in 2005 more than 75% of medical students came from families in the top 2 quintiles of family income, and that this trend has been consistent for at least 18 years.[13] This creates potential cause for concern because applicants of modest means may decide they cannot afford medical school as tuition continues to increase. If the burden of caring for patients falls mainly to the economically advantaged, differences in physical location, primary language, and culture may make it difficult for privileged physicians to properly care for lower socioeconomic populations. Moreover, as debt causes young physicians to be more concerned about their finances, it will inevitably divert attention from their ethical obligation to promote social justice.

A third important factor is the US culture of "individualism." While general western philosophy has shaped US culture, the unique history of the United States has created a special emphasis on individualism, entrepreneurial capitalism, and personal responsibility. Specifically regarding health care, many other western nations have some form of universal coverage supported by their government and treat health care as a public good.[14] In the United States, health care only intermittently has been treated as a public good and an intense debate regarding the promotion of government health programs vs the philosophy of individual responsibility and allowing market forces to work is ongoing.

While not all survey data agree, the emphasis on individual responsibility may be deepening. For example, the percentage of Americans who agree that the higher the income, the more the individual should expect to pay in taxes to cover the cost of care for individuals who are less well off decreased from 66% in 1991 to 51% in 2003 and to 39% in 2006.[15] The possible diminishing belief that the most fortunate should help care for the least fortunate is a troubling trend that does not appear to be as pronounced in other westernized countries with a history of providing health care as a public good.[14] If this trend indicates an evolving US attitude about social justice and caring for the less fortunate,

it is difficult to imagine that US physicians are immune to this way of thinking.

Confronting the Tough Questions

Despite issues that physicians cannot solely control, such as the widespread attitude of individual responsibility, the current dysfunctional state of health care delivery, and a reimbursement system built on counterproductive incentives, some might argue that physicians' ethical obligations do not allow them to divest themselves of shared responsibility for the injustices that exist as a result of a failing health care system. As a key control point in the overall allocation and utilization of health services, physicians have an ethical responsibility to analyze their personal role in creating a just or unjust society.

A key first step for physicians is to openly discuss challenging questions that have been avoided in recent years. However, discussion is not sufficient; each physician and each medical professional group must also answer these questions, including the following: are the inefficiencies of old delivery models and 1- or 2-physician practices acceptable any longer; is it time to correct the imbalance of reimbursement for procedures and acute care vs preventive and primary care services; and must the basic behavior of US physicians shift from one of autonomous, market-based individualism to one of greater social accountability and team behavior?

Physicians have a responsibility to ask and answer these difficult questions that are properly viewed as not simply involving politics, but rather as speaking to fundamental medical ethics. The answers in turn may well require personal sacrifices (eg, accepting a lower level of income), professional group action (eg, advocating as much for health care system improvements as current advocacy for the preservation of specialty reimbursement levels), and a commitment to work within the political process (that goes beyond lobbying for maintenance of the status quo). These efforts and corresponding sacrifices are necessary first steps toward creating a society in which everyone has access to appropriate health care.

Financial Disclosures: None reported.
Additional Contributions: We thank Susan Ehringhaus, JD, and Susan Monseur, BS, Association of American Medical Colleges, for their help in the preparation of this article. Neither individual received additional compensation for their work in association with this article.

REFERENCES

1. Emanuel EJ, Fuchs VR. The perfect storm of overutilization. *JAMA*. 2008; 299(23):2789-2791.
2. Emanuel EJ. The cost-coverage trade-off: "it's health care costs, stupid." *JAMA*. 2008;299(8):947-949.
3. Jost TS, Emanuel EJ. Legal reforms necessary to promote delivery system innovation. *JAMA*. 2008;299(21):2561-2563.
4. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics.* 6th ed. New York, NY: Oxford University Press; 2008.
5. Pellegrino ED. Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship. *J Contemp Health Law Policy*. 1994; 10:47-68.
6. Kluge EH. Resource allocation in healthcare: implications of models of medicine as a profession. *MedGenMed*. 2007;9(1):57.
7. Mathews SC, Pronovost PJ. Physician autonomy and informed decision making: finding the balance for patient safety and quality. *JAMA*. 2008;300(24): 2913-2915.
8. Hartzband P, Groopman J. Money and the changing culture of medicine. *N Engl J Med*. 2009;360(2):101-103.
9. Gillon R. Justice and medical ethics. *Br Med J (Clin Res Ed)*. 1985;291(6489): 201-202.
10. Adler N, Stewart J, Cohen S, et al. *Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S.* San Francisco, CA: The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health; 2008.
11. Weiss GG. Medical ethics: your heart versus your wallet. *Med Econ*. 2008; 85(10):42-44, 46-48.
12. Steinbrook R. Medical student debt—is there a limit? *N Engl J Med*. 2008; 359(25):2629-2632.
13. Jolly P. Diversity of U.S. medical students by parental income. Association of American Medical Colleges Web site. http://www.aamc.org/data/aib/aibissues/aibvol8_no1.pdf. Accessed December 17, 2008.
14. Mackenbach JP, Stirbu I, Roskam AJ, et al; European Union Working Group on Socioeconomic Inequalities in Health. Socioeconomic inequalities in health in 22 European countries. *N Engl J Med*. 2008;358(23):2468-2481.
15. Lee TH, Emanuel EJ. Tier 4 drugs and the fraying of the social compact. *N Engl J Med*. 2008;359(4):333-335.

